82 - 1805

No. _____

IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

JOHNSON COUNTY MEMORIAL HOSPITAL, ET AL.,*
*Petitioner**

vs.

RICHARD S. SCHWEIKER, SECRETARY OF
HEALTH AND HUMAN SERVICES,
Respondent.

PETITION FOR WRIT OF CERTORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

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*See inside cover for complete list of Petitioners.

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JOHNSON COUNTY MEMORIAL HOSPITAL,
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CLARK COUNTY MEMORIAL HOSPITAL,
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ADAMS COUNTY MEMORIAL HOSPITAL,
LAFAYETTE HOME HOSPITAL,
BLACKFORD COUNTY HOSPITAL,
BROADWAY METHODIST HOSPITAL,

Petitioners.

QUESTIONS PRESENTED

1. Does the decision below conflict with other decisions of other Courts of Appeals as to the proper interpretation of 42 U.S.C. §1395x(v)(1), and Medicare Regulation 42 CFR §405.451.

2. Does the decision below conflict with applicable decisions of this Court in that the decision applied legislation retroactively in violation of the Fifth Amendment to the Constitution of the United States.

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CITATIONS AND AUTHORITIES

MISC.:

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Respondent.

PETITION FOR WRIT OF CERTORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

PRAYER

Petitioners Johnson County Memorial Hospital, et al., respectfully pray that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Seventh Circuit entered in this preceeding on February 1, 1983.

OPINION BELOW

The opinion of the Court of Appeals, not yet reported, appears in the Appendix hereto. The opinion rendered by the District Court of Southern Indiana also appears in the Appendix.

JURISDICTION

The judgment of the Court of Appeals for the Seventh Circuit was entered on February 1, 1983. This petition for certiorari was filed within ninety (90) days of that date. This Court's jurisdiction is invoked under 28 USC §1254(1).

STATUTORY PROVISION INVOLVED

Section 1395x(v)(1)(A) of Title 42 provides:

> "(v)(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of sevices furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, and provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to

individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive."

STATEMENT OF THE CASE

The jurisdiction of the district courts was invoked under Chapter 7 of Title V of the Administrative Procedure Act, 5 U.S.C. §706, and 42 U.S.C. §1395oo(f)(1).

Petitioners are fifty-one (51) general, acute care, not-for-profit or county hospitals located in the State of Indiana who participate in the Medicare program contained in Title XVIII of the Social Security Act, 42 USC §1395, et seq., and in the Hill-Burton program contained in 42 USC §291. Petitioners sought reimbursement under the Medicare program for the cost incurred by each of them in the rendering of uncompensated care under the Hill-Burton program.

All of the Petitioners claimed their respective costs of rendering uncompensated care under the Hill-Burton

program in their cost reports for the fiscal periods ending between December 31, 1977 and June 30, 1978. The Fiscal Intermediary, Blue Cross Association/Mutual Hospital Insurance, Inc., disallowed these costs and Appellees perfected a group appeal to the Provider Reimbursement Review Board (hereinafter "PRRB"). An evidentiary hearing was held before the PRRB, and the PRRB affirmed the Intermediary's adjustment and held that the hospitals could not be reimbursed for the costs of their respective Hill-Burton uncompensated care services. The Administrator of the Health Care Financing Administration, to whom the Secretary of Health and Human Services (hereinafter "HHS") has delegated the responsibility of administering the Medicare Act, declined to reverse, affirm or modify the decision of the PRRB and thus, the decision of the PRRB became final.

Appellees appealed to their respective district courts in Indiana pursuant to 42 USC §139500(f)(1) and then consolidated both actions in the United States District Court for the Southern District of Indiana, Indianapolis Division.

Review was conducted by the District Court pursuant to Chapter 7 of Title V of the Administrative Procedure Act, 5 USC §706.

The District Court rejected the analysis and decision of the PRRB and concluded that the "Hill-Burton free care obligation costs are indirect costs within the meaning of the Medicare legislation and as such should be proportionately reimbursable." *Johnson County Memorial Hospital v. Schweiker*, 527 F. Supp. 1134 at 1139 (S.D. Ind. 1981). The District Court further held that "the Hill-Burton free care obligation is so like interest on building loans that it would be arbitrary and capricious to exclude the indirect costs of the free care obligation from the Medicare reimbursement calculus if interest on building loans is to be included." 527 F. Sup. 1134 at 1140. Accordingly, the District Court entered judgment for the Plaintiffs and remanded the

matter to the PRRB for a determination of the factual issues as to the amount of reimbursement.

From this decision, the Respondents appealed to the United States Court of Appeals for the Seventh Circuit. That court reversed the lower court's decision in its opinion, *Johnson County Memorial Hospital, et. al., v. Richard Schweiker, Secretary of Health and Human Services*, No. 82-1213 (February 1, 1983).

The Court of Appeals held that the Petitioner's claim for reimbursement was precluded by Section 106 of the Tax Equity and Fiscal Responsibility Act of 1982, ("hereinafter "TEFRA") and the Seventh Circuit's decision in *St. Mary of Nazareth Hospital v. Department of Health and Human Services*, No. 82-1237 (February 1, 1982).

REASONS FOR GRANTING THE WRIT

1. The Decision Below Conflicts with the Decision of the Fifth Circuit Court of Appeals as to the Proper Interpretation of 42 U.S.C. §1395x(v)(1)(A) and Medicare regulation 42 CFR §405.451

The Seventh Circuit held that TEFRA applied retroactively, and therefore, no Hill-Burton costs could be reimbursed. To reach this conclusion, the court was required to reach the substantive issue of the existence of a vested contractual right prior to 1982. The Seventh Circuit's decision that there were no vested contractual rights to reimbursement conflicts with the Fifth Circuit's decision on the same issue in *Presbyterial Hospital of Dallas v. Harris*, 638 F.2d 1381 (5th Cir. 1981).

Section 1395x(v)(1) of Title 42 directs and authorizes the Secretary of HHS to adopt regulations consistent with congressional intent defining the term "reasonable costs" as the term applies to the reimbursement of Medicare expenses. Hospitals qualified as providers of medical services to Medicare beneficiaries are reimbursed for the reasonable cost of the medical care rendered to Medicare

beneficiaries by private organizations acting as "fiscal intermediaries" under contract with the Secretary. 42 U.S.C. §1395h. At the end of a hospital's fiscal year, the hospital submits a cost report to the designated fiscal intermediary, and the fiscal intermediary conducts an audit of the cost report to ascertain the amount of reimbursable "reasonable costs" the hospital has incurred. 42 C.F.R. §405.406(b). It is the fiscal intermediary's responsibility to allow or disallow in accordance with the Secretary's regulations those items claimed as "reasonable costs" by the hospital.

The Petitioners are fifty-one hospitals located throughout the state of Indiana, and each of these hospitals received federal funds for either the construction or modernization of their medical facilities in the form of grants under the federal program known as the Hill-Burton Act. 42 U.S.C. §291. In consideration for their Hill-Burton grant, both the grant agreement and the Act requires participating hospitals to provide a reasonable volume of uncompensated care to those persons unable to pay for the care. The Secretary of HHS adopted regulations that required hospitals who received Hill-Burton funds to provide a percentage of uncompensated care to persons in the cost years in question based on one of the following three formulas: not less than the lesser of (1) 10% of all federal assistance received under the Hill-Burton Act; or (2) 3% of the hospital's net operating costs. As a third alternative, in order to fulfill its obligation arising out of the receipt of Hill-Burton funds, a participating hospital could elect to have an "open door" policy whereby it would provide uncompensated care to all persons admitted to the hospital in need of medical care or treatment who could not pay for it. 42 C.F.R. §153.111. Of the hospitals involved in this appeal, forty-five (45) elected to provide free care to indigents based upon the open door policy and six (6) of the hospitals decided to provide uncompensated care based upon the 10% formula.

The Petitioners seek Medicare reimbursement on the primary theory that the cost of providing free care is an indirect cost of the Medicare program. In the alternative, the Petitioners assert that the cost in providing free care under the Hill-Burton Act is so much like interest for the use of borrowed funds that it would be arbitrary and capricious to exclude the indirect costs of this free care obligation while reimbursing hospitals for interest on borrowed funds.

The Seventh Circuit held that the costs of providing Hill-Burton free care may not be reimbursed under Medicare because Congress did not intend these costs to be included in the term "reasonable costs" under 42 U.S.C. 1395x(v)(1). This determination was based upon the language and legislative history of TEFRA. TEFRA became law after the District Court opinion was rendered herein and while this case was pending before the Seventh Circuit Court of Appeals. In Section 106 of TEFRA, "reasonable costs" for Medicare reimbursement are defined to exclude Hill-Burton free care costs as follows:

> "(a) Section 1861(v)(1) of the Social Security Act [42 U.S.C. §1395x(v)(1)] is amended by adding at the end the following new subparagraph:
>
> > '(M) Such regulations shall provide that costs respecting care provided by a provider of services, pursuant to an assurance under Title VI or XVI of the Public Health Service Act that the provider will make available a reasonable volume of services to persons unable to pay therefore, shall not be allowable as reasonable costs.'
>
> (b) The amendment made by subsection (a) shall be effective with respect to any costs incurred under Title XVIII of the Social Security Act, except that it shall not apply to costs which have been allowed prior to the date of the enactment of this Act pursuant to the final court order affirmed by a United States Court of Appeals."

Congress also provided the following statement of congressional intent:

"Conference Agreement

> "The Conference Agreement includes the House Committee Provision. *The provision is intended to clarify that Hill-Burton free care costs have never been, and are not allowable for Medicare reimbursement purposes.* The provision, therefore, applies to all such costs that have been, or will be incurred except those recognized by the final judgment of a U. S. Court of Appeals entered into prior to enactment." (Emphasis supplied.)

To suggest in 1982 that the 1965 Congress never intended to reimburse hospitals for a cost which was purely nonexistent at the time, is to provide legislative intent where it did not exist. Subsequent Congressional pronouncements should not be considered as legislative history in interpreting a statute. *Haynes v. United States*, 390 U.S. 85, 87 n.4 (1968); *United Airlines, Inc. v. McMann*, 434 U.S. 192, 200 n.7 (1977); *Wisconsin Cheesman, Inc. v. United States*, 388 F.2d. 420, 423 (7th Cir. 1968).

At the time Section 106 was promulgated, the only decision that allowed the costs of providing Hill-Burton care to be reimbursed that had been affirmed by a United States Court of Appeals was *Presbyterian Hospital of Dallas v. Harris, supra.*

Thus, the Seventh Circuit gave retroactive effect to the provisions of TEFRA. The court defended this action by finding that the hospitals had no vested contractual right to Medicare reimbursement of the costs the hospitals incurred in providing a percentage of free care to local indigents in fulfilling their Hill-Burton obligations. In deciding the issue of vested contractual rights, the Seventh Circuit reached the substantive issue of whether "reasonable costs," as stated in 42 U.S.C. 1395x(v)(1), include the cost of providing free care to indigent persons in

fulfillment of contractual and statutory obligations under the Hill-Burton Act.

The Seventh Circuit decision, to the extent that it decided the substantive issue of vested rights prior to TEFRA, conflicts with the Fifth Circuit decision in *Presbyterian Hospital of Dallas v. Harris, supra.* A review of the well reasoned opinion in *Presbyterian Hospital* reveals that the Fifth Circuit carefully reviewed the precise terms of the Medicare Act and regulations. The Fifth Circuit found that the costs of free care are incidental allowable costs similar in nature to interest or depreciation, neither of which go directly to benefit Medicare patients, but which nonetheless inure as a residual benefit to them and are thus compensable on that basis. *Presbyterian Hospital, supra,* at 1386-1387.

In its decision, the Seventh Circuit relied on its decision in *St. Mary of Nazareth Hospital v. Department of Health and Human Services,* No. 82-1237 (7th Cir. 1982) for its ruling on the substantive issue. In *St. Mary,* the Seventh Circuit stated that its review of the Medicare statutes and regulations revealed no intention on the part of the Congress to allow reimbursemnet from one federal program for costs incurred in a separate and distinct federal program.

The Fifth Circuit observed that both direct and indirect costs are recoverable under 42 USC §1395x(v)(1) and 42 CFR 405.451. *Presbyterian Hospital, supra* at 1387. Indirect costs such as depreciation, interest, some types of bad debt, research costs, and even a return on equity capital of proprietary owners are all reimbursable. The court was unable to distinguish between free care expenses and interest. Interest on outstanding loans is clearly reimbursable under 42 CFR §405.419(b) *Presbyterian Hospital, Id.* The court reasoned that the free care "expense" indirectly benefited Medicare patients by qualifying the hospital for interest subsides, provided through the Hill-Burton program, for construction and

modernization projects. The fact that the expenses of the Hill-Burton program benefit non-Medicare patients was held to be irrelevant. The determining factor is whether the expenses were a reasonable cost incurred in the provision of services to Medicare patients.

In *St. Mary of Nazareth Hospital Center v. Department of Health and Human Services, et.al., supra,* decided on the same day as the present case, the Seventh Circuit stated that there was no evidence that the Congress ever intended the Medicare program to reimburse hospitals for the Medicare percentage of the cost of providing medical care pursuant to the hospital's Hill-Burton obligations. Thus, the Seventh Circuit's interpretation of the statutory language and legislative history of the Medicare and Hill-Burton programs conflicts with that of the Fifth Circuit.

2. The Decision Below Conflicts with Applicable Decisions of this Court in that it Applied Legislation Retroactively in Violation of the Fifth Amendment to the Constitution of the United States.

Petitioners have a vested contractual right to be reimbursed by the Medicare program for Hill-Burton indigent care costs. The appropriate Medicare statute, however, provides that a provider hospital is eligible for payments under the Medicare program only if it files an agreement pursuant to 42 U.S.C. §1395 cc (§1866 of the Social Security Act) with the Secretary. The form agreement is denominated as HCFA-1561 and is located in CCH Medicare and Medicaid Guide ¶10,440. The fact that the Medicare agreement constitutes a binding contract should not be challenged by the Secretary since he has prevailed in litigation in which he has sued for breach of contract under this form of provider agreement. *United States v. Upper Valley Clinic Hospital,* 615 F.2d 302 (5th Cir. 1980). The contract between Appellees and the Secretary grants to the hospitals a cognizable right for

reasonable cost reimbursement. This right includes the right to be reimbursed for the reasonable cost of providing Hill-Burton uncompensated services.

By the enactment of Section 106 of TEFRA, Congress, at the behest of the Secretary, has attempted to repudiate the government's financial obligation under the Medicare Act to pay Hill-Burton indigent care costs which are part of the cost incurred by Hill-Burton assisted facilities in providing care to Medicare beneficiaries. The Seventh Circuit's decision prohibits payment for services received by retroactive application of Section 106 to services rendered by Petitioners prior to the effective date of TEFRA. Such unilateral repudiation of the hospitals' contract rights and of the vested financial obligations by the federal government constitutes a taking of property without just compensation in violation of the Fifth Amendment. *Lynch v. United States*, 292 U.S. 571 (1934).

In *Lynch*, a unanimous Supreme Court sustained the right of beneficiaries of War Risk Insurance policies, which had been issued by the Government, to recover on these policies despite the existence of the Economy Act of 1933 which provided that "all laws granting or pertaining to yearly renewable term insurance are hereby repealed..." The Court held that the statute violated the Fifth Amendment due process clause as a taking of property without just compensation. In support of its conclusion, the Court stated:

> "The Fifth Amendment commands that property be not taken without making just compensation. Valid contracts are property, whether the obligor be a private individual, a municipality, a state or the United States. Rights against the United States arising out of a contract with it are protected by the Fifth Amendment."

Id. at 579. The Court went on to state that:

> "...Congress [is] without power to reduce expenditures by abrogating contractual obligations of the United

> States. To abrogate contracts, in the attempt to lessen government expenditure, would be not the practice of economy, but an act of repudiation. The United States are as much bound by their contracts as are individuals. If they repudiate their obligations, it is as much repudiation, with all the wrong and reproach that term implies, as it would be if the repudiator had been a state or a municipality or a citizen."

Id. at 580. The vitality of the holding in *Lynch* is evidenced in numerous subsequent cases dealing with the constitutionality of state and federal legislation retroactively repudiating contractual rights flowing from the government to individuals. *See, e.g., United States v. Larionoff*, 431 U.S. 864, 879 (1977) (action by re-enlisted members of U.S. Navy for bonuses under the terms of the Variable Reenlistment Bonus Program); *United States Trust Company of New York v. New Jersey*, 431 U.S. 1, 26 (1977); *Thorpe v. Housing Authority of the City of Durham*, 393 U.S. 268, 278-9 (1969); *Blanchette v. Connecticut General Insurance Corps.*, 419 U.S. 102, 134-5 (1974); *South East Chicago Commission v. Department of Housing and Urban Development*, 488 F.2d 1119 (7th Cir. 1973); *Everette Plywood Corp. v. United States*, 651 F.2d 723, 727 (Ct. Cl. 1981). *See generally, Forbes Pioneer Boat Line v. Board of Commission of Everglades Drainage District*, 258 U.S. 338 (1922); *Coombes v. Getz*, 285 U.S. 434 (1932); *Ettor v. City of Tacoma*, 228 U.S. 148 (1913); *Hoyt Metal Co. v. Atwood*, 289 F. 453 (7th Cir. 1923); *Fisher v. Police Jury of Jefferson, Left Bank*, 116 U.S. 1311 (1885).

The test for constitutionality of statutes retroactively impacting on contractual rights flowing from the government to individuals must be judged by the court's close scrutiny of three factors comprising a means-end rationality test: (a) the nature and the strength of the public interest served by the statute; (b) the extent to which the statute modifies or abrogates the asserted pre-enactment right; and (c) the nature of the right which the statute

alters. *See Nachman Corp. v. Pension Benefit Guaranty Corp.*, 592 F.2d 947, 959-960 (7th Cir. 1979); Hochman, *The Supreme Court and the Constitutionality of Retroactive Legislation*, 73 Harv. L. Rev. 692, 697 (1960).

Respecting the first element of the test, where the court finds that the challenged statute with retroactive application serves "no discernible public purpose" other than the bald avoidance of the government's financial obligations, then the provision will fail constitutional muster. *Lynch v. United States, supra; Treigle v. Acme Homestead Association;* 297 U.S. 189 (1936); *see also, E & E Hauling, Inc. v. Forest Preserve District of Due Page County, Illinois*, 613 F.2d 675, 681 (7th Cir. 1980).

Respecting the extent of the abrogation of the asserted preenactment contractual right, unconstitutionality typically results where retroactive application of a statute completely destroys preexisting rights to which it applies, particularly where the individual whose contractual right is abrogated has acted in reliance upon that right. *See, e.g., Ochoa v. Hernandes v. Morales*, 230 U.S. 139 (1913); Hochman, *The Supreme Court and the Constitutionality of Retroactive Legislation, supra* at 711.

Finally, concerning the nature of the right affected by the retroactive statute, statutes which impair or diminish the financial obligations of the government to individuals have failed absent a clear showing of an important public purpose. Close scrutiny of such statutes by the courts has been justified by the obvious governmental self-interest implicit in the enactment of such statutes. *United States Trust Co. of New York v. New Jersey, supra; United States v. Larionoff, supra; see, Nachman Corp. v. Pension Benefit Guaranty Corp., supra* at 959 n. 23 (7th Cir. 1979); *Caola v. United States*, 404 F. Supp. 1101 (D. Conn. 1975). As the Supreme Court recognized in a closely analogous case decided under the Contract Clause where New Jersey attempted abrogation of its financial obligations to individuals:

> "If a State can reduce its financial obligations whenever it wanted to spend the money for what it regarded as a public purpose, the Contract Clause would provide no protection at all.

United States Trust Co., supra, at 26.

There is no dispute that Petitioners have a contractual right to reimbursement of the reasonable, necessary and actual costs of providing services to Medicare beneficiaries. For reasons previously briefed at length, an element of that contractual right is Hill-Burton uncompensated care cost reimbursement.

There is no discernible public purpose for the statute other than simply reducing federal government expenditures in accordance with the present Administration's domestic fiscal policy. The regulatory interest which will avoid the *Lynch* doctrine must go beyond enrichment of the government coffers. The retroactive application of Section 106 would completely eliminate the Petitioners' contractual right to Hill-Burton care cost reimbursement under the Medicare Act. Finally, the statute impacts in favor of the government upon purely financial obligations at the expense of hospitals with vested contractual rights. These hospitals accepted Hill-Burton financial assistance under the contractual expectation of recouping uncompensated care costs from their entire hospital population. Such hospitals have adopted and implemented rate schedules for their entire nonindigent patient population in reliance upon this expectation. Retroactive abrogation of the government's obligation leaves the Medicare portion of those costs unfunded. Thus, the retroactive application of Section 106 is prohibited under each of the three factors in the means-end rationality test.

CONCLUSION

The Petitioner prays that this Court grant a writ of certiorari to review the decision of the Seventh Circuit Court of Appeals.

Respectfully submitted,

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

JOHNSON COUNTY MEMORIAL HOSPITAL, ET AL.,

Plaintiffs,

vs.

RICHARD S. SCHWEIKER, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, LEONARD D. SCHAEFFER, ADMINISTRATOR, HEALTHCARE FINANCING ADMINISTRATION,

Defendants.

MEMORANDUM OF DECISION

Plaintiffs are 51 general, acute care, not-for-profit or county hospitals located in the State of Indiana which participate in the Medicare program contained in Title XVIII of the Social Security Act, 42 U.S. C. §1395, et. seq., and in the grant program established by the Hill-Burton Act, 42 U.S.C. §291. Plaintiffs seek review of the defendants' decision not to include the cost of uncompensated care obligations mandated by participation in the Hill-Burton program as reimbursable costs under the Medicare program. Jurisdiction is based on 42 U.S.C. §1395oo(f)(1). The matter now comes before the Court on the parties' cross-motions for summary judgment.

The basic question presented for determination is that of how to reconcile two separate bodies of legislation which have not been coordinated by Congress.

The Medicare Act was passed in 1965. It provides that participating hospitals will be reimbursed for the reasonable cost of providing medical services to Medicare beneficiaries. 42 U.S.C. §1395f(b). The Act defines "reasonable cost" in 42 U.S.C. §1395x(v)(1)(A):

"The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services.... Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive."

Pursuant to this statutory authority, the Secretary of Health and Human Services has promulgated regulations which define reasonable cost more fully. 42 CFR §§405.401-405.488. The concept of reasonable cost is described in 42 CFR §405.451 as including "all necessary and proper costs." Necessary and proper costs are defined as costs:

"...which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs which are common and accepted occurrences in the field of the provider's activity." 42 CFR §405.451(b)(2).

The section states that reasonable cost includes direct and indirect costs: the objective is that costs stemming from

providing services to Medicare beneficiaries under the program should not be borne by non-Medicare patients and that costs due to treating non-Medicare patients not be borne by the program. 42 CFR §405.451(b)(1) and (c)(3).

The Hill-Burton Act, 42 U.S.C. §291, et. seq., was passed in 1946 to provide federal money for the construction and modernization of hospitals in order to assure adequate hospital services to all. 42 U.S.C. §291. In order to receive this federal aid, hospitals are required to provide a reasonable amount of free care to people unable to pay for such care. 42 U.S.C. §291c(e)(2). Until 1972, the amount of free care that would be considered reasonable was not specified. In 1972, the Department of Health and Human Services specified that a reasonable amount of free services was an amount equal to: (1) 10% of the federal aid given; (2) 3% of operating costs; or (3) care to all indigents appearing at the hospital in need of care (the open door policy). 42 CFR §53.111(d).

Each of the plaintiffs entered into a Hill-Burton grant agreement with the United States government. In doing so, each hospital incurred an obligation to provide a reasonable amount of free care to indigents.

The plaintiffs then sought to include their respective Hill-Burton uncompensated care costs as allowable indirect costs or as interest expenses in order to get reimbursement under the Medicare Act. The Fiscal Intermediary, Blue Cross Association/Mutual Hospital Insurance, Inc. ("Blue Cross"), disallowed these costs. The plaintiffs appealed to the Provider Reimbursement Review Board (PRRB). The PRRB affirmed the Blue Cross decision.

This PRRB decision became final when the Administrator of the Health Care Financing Administration, to whom the Secretary of Health and Human Services has delegated the responsibilty of administrating the Medicare Act, declined to reverse, affirm, or modify the decision of the PRRB. Plaintiffs now appeal to this Court.

Judicial review of the PRRB's final decision not to reimburse plaintiffs for their Hill-Burton costs is based on 42 U.S.C. §1395oo(f)(1) which provides:

> "A decision of the board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or any reversal, affirmance, or modification by the Secretary by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Such action shall be brought in the District Court of the United States for the judicial district in which the provider is located or in the District Court of the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of Title 5, notwithstanding any other provisions in Section 405 of this Title."

It must be noted that 26 of the plaintiffs are located in the Northern District of Indiana and that the other 25 plaintiffs are located in the Southern District of Indiana. The 26 plaintiffs from the Northern District of Indiana originally filed an action in the United States District Court for the Northern District of Indiana as Cause No. H 79-551 on November 15, 1979. The action was ordered transferred to this court and filed as Cause No. IP 79-1018-C and then consolidated with the action brought by the other 25 plaintiffs in this court as Cause No. IP 79-905-C.

It could be argued that the transfer of the cause filed in the Northern District of Indiana raises an issue of improper venue. Jurisdiction is conferred to the federal district courts to review reimbursement decisions by 42 U.S.C. §1395oo(f)(1), but that section goes on to provide that the proper court for such actions is either the District Court for the District of Columbia or the federal district court for

the judicial district in which the provider is located. Even assuming an original improper venue, the defendants have waived any objection they might have had by not interposing a timely and sufficient objection. Therefore, the Court's jurisdiction over this matter and over these parties is not impaired. 28 U.S.C. §1406(b).

The standard of review of the decision to deny reimbursement is that standard contained in 5 U.S.C. §§701, et. seq. The applicable provision is 5 U.S.C. §706(2) which provides, in pertinent part, that a reviewing court shall hold unlawful and set aside agency action, findings, and conclusions found to be arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.

The issue to be resolved is how the free care costs incurred by provider hospitals in order to obtain federal monies to build or improve hospital facilities fit into the reimbursement of expenses scheme of the Medicare Act. As mentioned earlier, the Medicare Act reimburses hospitals for the reasonable cost of any services, whether direct or indirect costs, provided to Medicare beneficiaries. The Secretary of Health and Human Services has promulgated numerous regulations listing the items to be included in reimbursement. For purposes of this case, only a few of these regulations are relevant.

Reasonable costs is defined as including both direct cost, the cost of services provided directly to Medicare beneficiaries, and a proportionate share of indirect cost, which are costs incurred for the benefit of all patients in the hospital. 42 CFR §405.451(b)(1) and (c)(3). In addition to this general definition, two specific inclusions and one specific exclusion from reimbursement are relevant.

Depreciation on assets financed by grants obtained under the Hill-Burton program is a reimbursable cost. 42 CFR §405.418(a). As explained in 42 CFR §405.418(b):

> "Like other assets (including other donated depreciable assets), assets financed with Hill-Burton

or other Federal or public funds become a part of the provider institution's plant and equipment to be used in rendering services. It is the function of payment of depreciation to provide funds which make it possible to maintain the assets and preserve the capital employed in the production of services. Therefore, irrespective of the source of financing of an asset, if it is used in the providing of services for beneficiaries of the program, payment for depreciation of the asset is, in fact, a cost of the production of those services. Moreover, recognition of this cost is necessary to maintain productive capacity for the future...."

Necessary and proper interest on current and capital indebtedness is also an allowable cost as provided in 42 CFR §405.419(a). Interest is defined as the cost incurred for the use of borrowed funds. 42 CFR §405.419(b)(1). To be "necessary," interest must (1) be incurred on a loan made to satisfy a financial need of the provider and (2) be incurred on a loan made for a purpose reasonably related to patient care. 42 CFR §405.419(b)(2). To be "proper," interest must be incurred at a prudent rate and must be paid to a lender not related to the provider through control or ownership. 42 CFR §405.419(b)(3).

Finally, charity care and bad debts are not reimbursable. Charity allowances are defined as "reductions in charges made by the provider of services because of the indigence or medical indigence of the patient." 42 CFR §405.420(b)(2). Charity care is viewed as a reduction in revenue. The regulation explains that the failure to collect charges for services rendered does not add to the cost of providing services, since that cost has already been incurred in giving the care. 42 CFR §405.420(c).

In light of these regulations governing reimbursement of costs under the Medicare Act, it is now possible to examine the arguments raised by plaintiffs for allowing the cost of Hill-Burton free care as a reimbursable expense.

Positions of the Parties

The plaintiffs maintain that their Hill-Burton free care costs are allowable indirect costs of the Medicare program. Plaintiffs also argue that Hill-Burton free care should be viewed as interest paid on a loan and thus reimbursable under 42 CFR §405.419. Alternatively, plaintiffs assert that, if the full cost of the Hill-Burton free care is not reimbursable, at least the excess of the cost over the depreciation reimbursed on Hill-Burton financed facilities allowed in 42 CFR §405.418(a) and (b) should be reimbursed.

The PRRB rejected these arguments, holding that Hill-Burton free care is not reimbursable since it is furnished to patients who are not Medicare patients. The PRRB reasoned:

> "The Board finds that to allow the cost of the free care would be in direct opposition to the legal and regulatory objective of determining reasonable cost whereby costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program (Section 1861(v)(1)(A) of the Social Security Act, as amended, and 42 CFR 405.402(a) and 451(b)(1)). The patients in this case receiving the free care fall into the latter category of patients. Inasmuch as they are not Medicare beneficiaries, their costs, the free care, may not be borne by the program." Administrative Record, p.0016.

The PRRB also held that reimbursement for Hill-Burton free care is barred by the prohibition of reimbursement for charity allowances contained in 42 CFR 405.420. The PRRB rejected plaintiffs' alternative request for reimbursement of free care cost in excess of the allowance for depreciation for the same reasons as it rejected reimbursement for the full cost.

Discussion

Very few courts have addressed the question raised by this case. Of the on-point cases brought to the attention of the Court or discovered in the Court's own research, only one unpublished district court opinion has gone in favor of the government. *Harper-Grace Hospitals v. Schweiker*, No. 80-72082 (E.D.Mich. 1981). Two more persuasive opinions on all fours with the case at bar have held that hospitals are entitled to Medicare reimbursement for a portion of the free care given to patients in fulfillment of the hospitals' Hill-Burton obligations. *Presbyterian Hospital of Dallas v. Harris*, 638 F.2d 1381 (5 Cir. 1981), and *Rapides General Hospital v. Matthews*, 435 F.Supp. 384 (W.D.La. 1977) (vacated and remanded on other grounds, No. 77-3125, 5 Cir., Oct. 23, 1978, unpublished order).

The PRRB has recently held that the Medicare proportion of Hill-Burton costs are reimbursable, in reliance on *Presbyterian Hospital, supra.* (See *Mount Diablo Hospital Medical Center v. Blue Cross Association/ Blue Cross of Northern California* (PRRB No. 81-D-85, Sept. 11, 1981); *Gaston Memorial Hospital, Inc. v. Blue Cross Association/Blue Cross Blue Shield of North Carolina* (PRRB No. 81-D-84, Sept. 11, 1981), and *Catholic Medical Center v. Blue Cross Association/New Hampshire-Vermont Health Service* (PRRB No. 81-D-87, Sept. 11, 1981).

The first major issue to be resolved is whether the Hill-Burton free care obligation is an indirect cost within the meaning of the Medicare Act. 42 U.S.C. §1395x(v)(1)(A), 42 CFR §405.451(b)(1) and (c)(3).

The PRRB's argument that the free care obligation should not be reimbursed because the services rendered to non-Medicare patients misapprehends the point of the free care obligation. The specific hospital services are indeed given to indigents, but they are given by the hopsital in exchange for the government interest subsidy. Medicare patients do benefit from the Hill-Burton grants: the free

care given to non-Medicare patients is simply a payment for the building improvements enjoyed both by them and by Medicare patients. This point was addressed by the court in *Rapides, supra.* The following language was noted with approval by the Fifth Circuit Court of Appeals in *Presbyterian Hospital of Dallas, supra,* at 388:

> "Defendant's opposition is a straightforward one. The indigents receiving Hill-Burton free care are persons other than those covered by medicare. Thus, their stature as 'individuals not so covered' automatically precludes the plaintiff from receipt of medicare payments as to their costs. But this response misapprehends the thrust of plaintiff's argument. Plaintiff does not assert that the free care beneficiaries are medicare recipients and that their costs are reimbursable as such. Rather, plaintiff argues that the costs of free care are incidental allowable costs, similar in nature to interest or depreciation, neither of which go [sic] directly to benefit medicare patients, but which nonetheless inure as a residual benefit to them and are thus compensable on that basis. Consequently, defendant's response functions in a misplaced context." *Rapides, supra,* at 388.

The hospital plaintiffs in this case are not arguing that the Hill-Burton care for indigents is a direct cost which should be subsidized by the Medicare program. Rather, they assert that it is an indirect cost of maintaining or expanding hospital buildings which inures to the benefit of every patient in the hospital. The Hill-Burton free care obligation is a legal duty imposed by the terms of the grant. The Medicare patients benefit from the improved physical plant which results from Hill-Burton grants as they benefit from other, specifically enumerated "necessary and proper costs such as heating and lighting." 42 CFR §405.451(b)(2).

The Hill-Burton free care obligation costs therefore are indirect costs within the meaning of the Medicare

legislation and as such should be proportionately reimbursable.

The plaintiffs' second argument is that the Hill-Burton costs are "interest" which is clearly reimbursable within the specific terms of 42 CFR §405.419(b). The problem with this assertion is that the regulation defines interest so that the Hill-Burton free care obligation does not fall within the literal terms of portions of this definition. For example, the Hill-Burton funds are not literally "borrowed." They are not repayed to a "lender." The funds are a grant which is repayed by furnishing a fixed amount of free care to indigents.

However, the Hill-Burton Act imposes specific duties on hospitals which accept Hill-Burton funds. Either the Attorney General or a private party may sue to enforce the free care obligation. (See 42 U.S.C. 300-6 and *Newsom v. Vanderbilt University*, 6553 F.2d 1100, 1107 (6 Cir. 1981).) This obligation functions exactly as does interest: hospitals accepting Hill-Burton funds must provide care to indigents in return for the grants. These funds are only acquired if the hospital agrees to "repay" the government by treating indigents without charge. In spirit, this free care obligation is an exact equivalent of interest, which is most generally defined as '...the cost incurred for the use of borrowed funds." 42 CFR §405.4l9(b)(1).

The *Rapides* court held, in its discussion of this issue:

> "We believe there exists an inherent inconsistency in allowing the cost of interest to be compensable by medicare, while at the same time disallowing the cost of the free care obligation. The source of both costs is the same. Both are costs imposed on the plaintiff as a result of the expansion of its facilities. The origins and goals of the cost differ. The interest cost arose out of the loan from the bank and is payable to the bank. The free care obligation arose out of the Hill-Burton loan guarantee and is owed to the indigent public. However, these variances are irrelevant insofar as we

> are concerned. The issue that is and remains before us is that *both* costs entail expenditures on the part of the plaintiff, and that the existence of both is compelled solely by the desire of the plaintiff to create additional means to alleviate the distress caused by health disorders suffered by both medicare and non-medicare patients." *Id.* at 388-89.

This Court concurs with that conclusion. The Hill-Burton free care obligation is so like interest on building loans that it would be arbitrary and capricious to exclude the indirect cost of the free care obligation from the Medicare reimbursement calculus if interest on building loans is to be included.

One remaining argument by the defendant is that the free care obligation is "charity," which is specifically excluded from the "reasonable cost of services' computation. 42 CFR §405.420. However, the free care rendered by the hospitals is a legally enforceable obligation.

The scant definition of charity allowances at 42 CFR §405.420(b)(2) provides:

> "*Charity allowances.* Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient."

The hospitals in this case have not provided these services because of the indigence of the patients, but rather because of their Hill-Burton free care obligations These free care obligations do not fall within the ordinary meaning of the term "charity" (see, e.g., *Webster's New Traditional Dictionary*, Second Edition: charity is an "eleemosynary gift" (when used in a legal contest), and "gift" is a "voluntary transfer of real or personal property without consideration").

The parties have not come forward with any cases which define "charity" within the meaning of the Medicare regulations, nor has the Court found any on its own

research. The Seventh Circuit has defined charity as a "gift." *Todd v. Citizen's Gas Company of Indianapolis*, 46 F.2d 855, 865 (7 Cir. 1931).

It is clear that this free care obligation is no gift; it is an obligation, a duty. The government's argument that the hospitals gave indigents free care before the obligation was imposed upon them is inapposite. Before they had accepted Hill-Burton funds, and particularly before the 1972 guidelines were established, these hospitals had the right to discontinue all free care to indigents. The acceptance of the Hill-Burton funds are conditioned upon the legal obligation to furnish free care to those unable to pay for hospital services. This "free" care is simply not charity. Therefore, no obstacle remains to the plaintiffs' recovery other than the issue of the amount of reimbursement. Although the plaintiffs have asked the Court for a ruling on this issue, the case will be remanded to the PRRB. That body must determine the extent to which each hospital has been reimbursed for its Hill-Burton free care expenses. To the extent that the plaintiffs have not been reimbursed, the PRRB must determine precisely what the Hill-Burton expenses are. See *Presbyterian Hospital, supra*, at 1388. It is inappropriate for the Court to make that type of factual determination *de novo*. As noted by the Fifth Circuit in the *Presbyterian Hospital* case, *supra:*

> "Where an error of law has been corrected by a reviewing court, and the only issues remaining in the case are questions which have not yet been considered by the administrative agency but are nevertheless within the agency's authority, the appropriate action is a remand to the agency so that it may exercise its authority. As the Supreme Court explained in *FPC v. Idaho Power Co.*, 344 U.S. 17, 20, 73 S.Ct. 85, 86, 97 L.Ed. 15 (1952), 'the guiding principle...is that the function of the reviewing court ends when an error of law is laid bare. At that point the matter once more goes to the Commission for reconsideration."[citations omitted]." *Id.*, at 1389.

The defendants' motion for summary judgment is hereby denied. The plaintiffs' motion for summary judgment is granted on the questions of law. This matter is hereby remanded to the PRRB for a determination of the residual factual issues in accordance with this decision.

Dated this 16th day of December, 1981.

S. Hugh Dillin, Judge

In the

United States Court of Appeals

For the Seventh Circuit

No. 82-1213

JOHNSON COUNTY MEMORIAL HOSPITAL, et al.,

Plaintiffs-Appellees,

v.

RICHARD S. SCHWEIKER, Secretary of Health and Human Services,

Defendant-Appellant.

Appeal from the United States District Court for the Southern District of Indiana, Indianapolis Division.
Nos. 79 C 905, 79 C 1018—S. **Hugh Dillin**, *Judge.*

ARGUED OCTOBER 27, 1982—DECIDED FEBRUARY 1, 1983

Before BAUER and COFFEY, *Circuit Judges,* and WISDOM, *Senior Circuit Judge.**

COFFEY, *Circuit Judge.* This is an appeal from the decision of the district court granting the plaintiffs' motion for summary judgment while denying the defendant's like motion on the grounds that the costs incurred by the plaintiffs in providing a percentage of free care to indigent persons in fulfillment of the hospitals' obligations

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* The Honorable John Minor Wisdom, Senior Circuit Judge of the United States Court of Appeals for the Fifth Circuit, is sitting by designation.

under the Hill-Burton Act did not constitute "charity allowances" and thus were reimbursable expenses under the Medicare program. Reverse.

The plaintiffs are fifty-one hospitals located throughout the state of Indiana, and each of these hospitals received federal funds for either the construction or modernization of their medical facilities in the form of grants under the federal program known as the Hill-Burton Act.[1] 42 U.S.C. § 291. In partial repayment of their Hill-Burton grant, the Act requires participating hospitals to provide a reasonable volume of free care to indigent persons residing in the hospitals' "territorial area." The Secretary of the United States Department of Health and Human Services has adopted regulations that direct hospitals who received Hill-Burton funds to provide a percentage of free medical care to local indigent persons based on one of the following three formulas: not less than the lesser of (1) 10% of all federal assistance received under the Hill-Burton Act; or (2) 3% of the hospital's net operating costs. As a third alternative, in order to fulfill its obligation arising out of the receipt of Hill-Burton funds, a participating hospital could elect to participate in the "open door" program and provide care to all local indigents admitted to the hospital and in need of medical care or treatment. 42 C.F.R. § 53.111. Of the hospitals involved in this appeal, forty-five elected to provide free care to indigents based upon the open door program and six of the hospitals decided to provide uncompensated care based upon the 10% formula.

All of the hospitals in this case have also been qualified by the Secretary of the Department of Health and Human Services as providers of Medicare services and as

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[1] The Hill-Burton Act was enacted in 1946 to assist in the construction and modernization of hospitals and to ensure adequate hospital services for all persons. As an obligation arising out of their receipt of federal funds under the Hill-Burton Act, hospitals are required to provide a reasonable volume of charity services to persons unable to pay therefore. 42 U.S.C. § 291c(e)

such, the hospitals are entitled to reimbursement from the Medicare program for the "reasonable costs" they incur in providing medical treatment to Medicare beneficiaries. 42 U.S.C. § 1395f(b). Under the Secretary's regulations, the Secretary enters into contracts with private organizations designated as "fiscal intermediaries"[2] who reimburse the hospitals for the "reasonable costs" the hospitals incur in providing medical treatment to Medicare patients and who are in turn reimbursed by the government for the sums they pay to the hospitals. Each of the hospitals involved in this case sought Medicare reimbursement from their fiscal intermediary (Blue Cross/Blue Shield) "on the primary theory that the free care obligation is an indirect cost of the Medicare Program." The hospitals argued in the alternative that "the cost in providing free care under the Hill-Burton Act constitutes interest for the use of borrowed funds and is reimbursable under the Medicare Program" as a "reasonable cost" of providing care to Medicare beneficiaries. The fiscal intermediary disallowed Medicare reimbursement of the "costs" claimed for the rendering of charity care to indigents pursuant to the hospitals' obligations under the Hill-Burton grant agreements, and the plaintiffs appealed to the Provider Reimbursement Review Board.[3] After a hearing, the Provider Reimbursement

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[2] Hospitals qualified as providers of medical services to Medicare beneficiaries are usually reimbursed for the reasonable cost of the medical care rendered to Medicare beneficiaries by private organizations acting as "fiscal intermediaries" under contract with the Secretary. 42 U.S.C. § 1395h. At the end of the hospitals' fiscal years, the hospitals submit cost reports to the designated fiscal intermediary, and the fiscal intermediary undertakes an analysis of the cost reports to ascertain the amount of reimbursable "reasonable costs" the hospitals incurred. 42 C.F.R. § 405.406(b). It is the fiscal intermediary's responsibility to allow or disallow in accordance with the Secretary's regulations those items claimed as "reasonable costs" by the hospitals. 42 C.F.R. § 1803.

[3] Congress established the Provider Reimbursement Board, and gave the Board the authority to conduct a hearing when a provider disputes the decision of a fiscal intermediary, if the

(Footnote continued on following page)

Review Board upheld the fiscal intermediary's finding that the free care hospitals provided to the indigent in fulfillment of their Hill-Burton obligation was a "charity allowance," an expense not reimbursable under the Medicare program. The Administrator of the Health Care Financing Administration, acting for and on behalf of the Secretary of the United States Department of Health and Human Services, declined to review, affirm or modify the decision of the Provider Reimbursement Review Board, and therefore the Board's decision became final. Thereafter, the hospitals sought review[4] of the Provider Reimbursement Review Board decision disallowing Medicare reimbursement for the costs the hospitals incurred in providing a percentage of free care to local indigent persons in partial repayment of their Hill-Burton obligations.

In ruling on the parties' cross motions for summary judgment, the district court found that the cost of providing a percentage of free care to indigents under the Hill-Burton Act indirectly inured to the benefit of Medicare patients because the free care given to indigents is "simply a payment for the building improvements enjoyed both by them [the indigents] and by Medicare

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[3] *continued*
total amount in controversy is at least $10,000. 42 U.S.C. §139500. In the instant case the Provider Reimbursement Review Board consolidated the appeals of the fifty-one Indiana hospitals into one appeal.

[4] Twenty-six of the hospitals involved in this case are located in the Northern District of Indiana, and therefore filed suit in the District Court for the Northern District of Indiana. The other twenty-five hospitals filed suit in the District Court for the Southern District of Indiana, as these hospitals are located in the Southern District of Indiana. Upon the motion of those plaintiffs who filed suit in the Northern District of Indiana, their case was transferred to the District Court for the Southern District of Indiana and was consolidated with the action brought by the other hospitals in that court. The decision in this consolidated case is reported as *Johnson County Memorial Hospital v. Schweiker*, 527 F. Supp. 1134 (S.D. Ind. 1981).

patients." The court ruled that "[t]he Hill-Burton free care obligation costs therefore are indirect costs within the meaning of the Medicare legislation and as such should be proportionately reimbursable." The court went on further to hold that the hospitals' obligation to provide a percentage of free indigent care functions exactly as interest on a loan since it arises out of the receipt of the monies used in the construction or modernization of the hospitals' medical facilities. The court concluded that "it would be arbitrary and capricious to exclude the indirect cost of the free care obligation from the Medicare reimbursement calculus if interest on building loans is to be included." Finally, the court found that because the hospitals were obligated to provide a percentage of free care to indigents under the Hill-Burton Act, this free care could not be characterized as "charity," as charity is freely given and does not arise out of an obligation. Based on this reasoning, the district court denied the defendant's motion for summary judgment while granting the plaintiffs' like motion, and the Secretary of the Department of Health and Human Services appealed from the decision of the district court.

ISSUE PRESENTED

> Are hospitals who provide medical services to Medicare beneficiaries entitled to Medicare reimbursement of a percentage of the cost of providing free care to indigent persons in fulfillment of their obligations under the Hill-Burton Act?

On September 3, 1982 section 106 of the Tax Equity & Fiscal Responsibility Act of 1982 became effective. Section 106 amended 42 U.S.C. § 1395x(v)(1) which directs and authorizes the Secretary of the United States Department of Health and Human Services to adopt regulations consistent with congressional intent defining the term "reasonable costs" as the term applies to the reimbursement of Medicare expenses. Section 106 provides:

> "(a) Section 1861(v)(1) of the Social Security Act [42 U.S.C. § 1395x(v)(1)] is amended by adding at the end the following new subparagraph:

'(M) Such regulations shall provide that costs respecting care provided by a provider of services, pursuant to an assurance under Title VI or XVI of the Public Health Service Act that the provider will make available a reasonable volume of services to persons unable to pay therefore, shall not be allowable as reasonable costs.'

(b) The amendment made by subsection (a) shall be effective with respect to any costs incurred under Title XVIII of the Social Security Act, except that it shall not apply to costs which have been allowed prior to the date of the enactment of this Act pursuant to the final court order affirmed by a United States Court of Appeals."

Congress also provided the following statement of congressional intent:

"*Conference Agreement*

The Conference Agreement includes the House Committee Provision. *The provision is intended to clarify that Hill-Burton free care costs have never been, and are not allowable for Medicare reimbursement purposes.* The provision, therefore, applies to all such costs that have been, or will be incurred except those recognized by the final judgment of a U. S. Court of Appeals entered into prior to enactment." (Emphasis supplied).

The plaintiffs contend that the retroactive application of section 106 is unconstitutional as it constitutes a taking of property without just compensation in violation of the fifth amendment. It is the hospitals' position that they have a vested contract right to Medicare reimbursement of the costs the hospitals incurred in providing a percentage of free care to local indigents in fulfillment of their Hill-Burton obligations. We refuse to accept the plaintiffs' position that they had a vested contractual right to Medicare reimbursement of the costs incurred in providing free health services to indigents because a fair reading of the Hill-Burton and Medicare Acts, from their inception, reveals that these two federal Acts as estab-

lished are separate and distinct federal aid programs, and Congress never intended to reimburse hospitals with Medicare funds for the free care the hospitals are obligated to perform under the terms of the Hill-Burton Act. Moreover, it would be improper to allow the hospitals to receive a double payment from the government, and Congress did not intend to compensate hospitals a second time for medical care for which the government has already paid through contractual agreements for indigent care under the Hill-Burton Act.

The disposition of this case is controlled by the holding in a case decided this date. In *Saint Mary of Nazareth Hospital v. Department of Health & Human Services*, No. 82-1237 (7th Cir. 1982), this court held that the retroactive application of section 106 was constitutional and that the Secretary of the Department of Health and Human Services acted properly in adhering to his long standing policy of disallowing Medicare reimbursement for the costs hospitals incurred in providing a percentage of indigent persons with free health care in partial fulfillment of their Hill-Burton contractual obligations. We reverse the finding of the district court and hold that the decision of *Saint Mary of Nazareth Hospital v. Department of Health & Human Services* is controlling as to the issues raised herein.

A true Copy:

Teste:

Clerk of the United States Court of Appeals for the Seventh Circuit

In the

United States Court of Appeals

For the Seventh Circuit

No. 82-1237

SAINT MARY OF NAZARETH HOSPITAL CENTER,

Plaintiff-Appellant,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,

Defendants-Appellees.

Appeal from the United States District Court for the
Northern District of Illinois, Eastern Division.
No. 81 C 2750—**Frank J. McGarr**, *Judge.*

No. 82-1253

ST. JAMES HOSPITAL,

Plaintiff-Appellee,

v.

RICHARD S. SCHWEIKER, Secretary of the Department of Health and Human Services,

Defendant-Appellant.

Appeal from the United States District Court for the
Northern District of Illinois, Eastern Division.
No. 80-C-735—**George N. Leighton**, *Judge.*

ARGUED OCTOBER 27, 1982—DECIDED FEBRUARY 1, 1983

Before BAUER and COFFEY, *Circuit Judges*, and WISDOM, *Senior Circuit Judge.**

COFFEY, *Circuit Judge.* This appeal is the consolidation of two conflicting district court decisions challenging the payment of Medicare funds to hospitals in reimbursement of Medicare's percentage of the costs incurred by hospitals in rendering medical care to indigents in fulfillment of the hospitals' obligations to the federal government as recipients of Hill-Burton funds. In *Saint Mary of Nazareth Hospital Center v. Department of Health and Human Services*, 531 F. Supp. 419 (N.D. Ill. 1981), the district court granted the defendant's motion for summary judgment on the grounds that the plaintiff hospital was not entitled to Medicare reimbursement for the percentage allocated to Medicare of the free care the hospital provided to indigents in fulfillment of its obligation under the Hill-Burton Act, while in the *St. James Hospital v. Harris*[1] case, 535 F. Supp. 751 (N.D. Ill. 1981), the court granted the plaintiff hospital's motion for summary judgment on the grounds that the hospital was entitled to such reimbursement. The *St. James Hospital* court also found that a bedside telephone furnished by a hospital was not a "personal comfort item" and thus the

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* The Honorable John Minor Wisdom, Senior Circuit Judge of the United States Court of Appeals for the Fifth Circuit, is sitting by designation.

[1] In a footnote, the court noted:

> "Patricia Roberts Harris, who is here sued only in her official capacity, has been succeeded in office by Richard S. Schweiker. However, for literary reasons, there having been no motion for substitution, the court has treated the case as against the Secretary during whose term of office this controversy arose. Under the circumstances, by operation of law, the substitution is automatic; and the judgment in this case is against the current incumbent who becomes the named defendant. *See Bracco v. Lackner*, 462 F. Supp. 436 (N.D. Cal. 1978); Fed. R. Civ. P. Rule 25(d), 28 U.S.C.A."

435 F. Supp. at 765 n.1. For the purpose of this appeal, the current Secretary has been substituted for Ms. Harris.

Secretary erred when he ruled that 42 C.F.R. § 405.310(j)[2] controlled and prohibited reimbursement of the costs the hospital incurred in furnishing bedside telephones to Medicare patients. We affirm *Saint Mary of Nazareth Hospital v. Dept. of Health and Human Services*, and reverse *St. James Hospital v. Harris.*

Saint Mary of Nazareth Hospital, located in Chicago, Illinois, is a 490 bed acute care general hospital and was rated qualified by the Secretary of the United States Department of Health and Human Services as a provider of medical services under the provisions of the Social Security Act relating to the Medicare program. 42 U.S.C. § 1395 *et seq.* (1976). Qualified hospital providers such as Saint Mary's are entitled to reimbursement for the reasonable costs of providing medical treatment to those qualified for Medicare benefits under the Social Security Act, as defined in the Secretary's regulations. 42 U.S.C. §§ 1395f(b), 1395x(v)(1)(A) (1976). A private health insurance organization (Blue Cross/Blue Shield) acting as a "fiscal intermediary"[3] initially analyzes the Medicare cost

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[2] 42 C.F.R. § 405.310(j) states:

"no payment may be made for any expenses incurred for the following items or services:

* * *

(j) Personal comfort items and services (for example a television set, or telephone service, etc.);"

[3] Medicare providers are usually reimbursed for the reasonable cost of care the hospitals render to Medicare beneficiaries by private organizations acting as "fiscal intermediaries" pursuant to contracts with the Secretary. 42 U.S.C. § 1395h. It is the fiscal intermediary's responsibility to ascertain the amount of reimbursable "reasonable cost" in accordance with regulations promulgated by the Secretary. At the end of the hospitals' fiscal years, the participating hospitals must submit cost reports to the fiscal intermediary documenting the "reasonable costs" provided to Medicare beneficiaries. 42 C.F.R. § 405.406(b). As the liaison between the government and the provider hospitals the fiscal intermediary determines whether the hospitals are acting in a fiscally responsible

(Footnote continued on following page)

reports submitted by hospitals, and after review of these cost reports, allows or disallows the costs claimed to have been incurred by the hospitals and reimburses the health care providers for the "reasonable cost" of the services rendered to Medicare beneficiaries. 42 C.F.R. § 405.401(c). In 1974 Saint Mary's entered into a contract with the federal government and received funds under the Hill-Burton Act to construct its present facility.[4] The Secretary's regulations implementing the Hill-Burton Act require that, in repayment of the grant, participating hospitals provide a percentage of free medical care and services to indigent persons residing in the hospitals' "territorial area," 42 U.S.C. § 291c(e), based on one of the following three formulas: not less than the lesser of (1) 10% of all federal assistance received under the Hill-Burton Act; or (2) 3% of the hospital's net operating costs. As a third alternative, the hospital could elect to adopt the "open door" policy and provide care to all local indigents who are admitted to the hospital and in need of medical care or treatment. 42 C.F.R. § 53.111. Saint Mary's elected to provide uncompensated care under the 10% formula and for the fiscal years 1977 and 1978 Saint Mary's provided free care to indigents amounting to $120,656 and $180,065 respectively. Saint Mary's then sought to have the Medicare program reimburse the hospital for the costs they incurred in fulfillment of their Hill-Burton obligation to indigents. The fiscal in-

[3] *continued*
manner and undertakes an analysis of the cost reports. 42 C.F.R. § 1803. After reimbursing the provider hospitals for the reasonable costs of the medical treatment the hospitals rendered to Medicare beneficiaries pursuant to the Secretary's regulations, the fiscal intermediary is itself reimbursed by the government.

[4] The Hill-Burton Act, 42 U.S.C. § 192 *et seq.*, was passed in 1946 to assist in the construction and modernization of hospitals and to assure adequate hospital services for all. In order for a participating hospital to receive federal funds under the Hill-Burton Act, the hospital must provide "a reasonable volume of services for persons unable to pay therefor." 42 U.S.C. § 291c(e).

termediary denied Medicare reimbursement of the "costs" claimed for the rendering of free care to indigents arising out of Saint Mary's Hill-Burton obligation. The Provider Reimbursement Review Board[5] upheld the decision of the fiscal intermediary. Thereafter, the Deputy Administrator of the Health Care Financing Administration acting for and on behalf of the Secretary of the Department of Health and Human Services declined to review the Provider Reimbursement Review Board's finding and thus the Board's administrative decision became final.

On May 18, 1981 St. Mary's Hospital brought this action and sought judicial review of the Provider Reimbursement Review Board's decision pursuant to 42 U.S.C. § 1395oo(f). The parties (Saint Mary's Hospital and the Secretary of the Department of Health and Human Services) each filed cross motions for summary judgment and the district court granted the Secretary's motion for summary judgment while denying Saint Mary's motion. In granting the Secretary's motion for summary judgment Judge McGarr ruled that Congress, in adopting the Medicare legislation did not intend to reimburse hospitals with Medicare funds for the expenses they incurred in providing a percentage of free services to indigents in repayment of their contractual financial obligation to the government as recipients of Hill-Burton funds. Agreeing with the rationale of the Provider Reimbursement Review Board, the court found that since the hospital had already received compensation for the free care it rendered to indigents under the Hill-Burton Act, if the federal government was now required to again pay for these free medical services to indigents with Medicare funds, the net result would be to "compensate the [hospital] a second time for those costs which the government has already paid." Citing *Gaston Memorial*

[5] The Provider Reimbursement Review Board is empowered to conduct a hearing when a provider is not satisfied with and disputes the decision of a fiscal intermediary, if the total amount in controversy is at least $10,000. 42 U.S.C. § 1395oo.

Hospital v. Blue Cross, PRRB No. 81-D84 (September 11, 1981). The court recited that it strained the bounds of logical reasoning to believe that Congress would require hospitals to provide a certain amount of free health care to indigents as compensation for receiving federal funds from one program and then reimburse the hospital with federal funds from another program for the obligation it originally incurred in accepting the Hill-Burton federal grant. Thus, the court upheld the Provider Reimbursement Review Board's ruling that the cost of providing free care to indigents pursuant to the hospital's Hill-Burton obligations was not a reimbursable expense under the Medicare program.

St. James Hospital, located in Chicago Heights, Illinois, is also a general hospital the Secretary of the United States Department of Health and Human Services found to be qualified as a provider of medical services under the Medicare program and thus entitled to reimbursement for the "reasonable costs" of providing health care services to qualified Medicare beneficiaries. 42 U.S.C. § 1395 *et seq.* (1976). St. James Hospital also received Hill-Burton grants[6] and elected to participate in the 10% formula for partial repayment of these grants. In 1977, in fulfillment of its Hill-Burton obligation St. James provided free medical care to indigents in the amount of $159,300. St. James' administrator calculated the percentage of the hospital's overall operating expenses as represented by Medicare patients and sought reimbursement from the Medicare program for this percentage of the hospital's cost of providing uncompensated care to indigents. St. James contends that its obligation to perform a percentage of free services to indigents under the Hill-Burton Act was a proper cost arising out of a financial transaction, and was akin to interest on a loan and therefore reimbursable under the Medicare program. The fiscal intermediary, in disallowing reimbursement, ruled that the Hill-Burton obligation to provide a per-

[6] St. James used these funds to modernize its existing facility and to construct new facilities.

centage of uncompensated medical care to indigents represented "charity allowances" and thus had "no relationship to beneficiaries of the health insurance program [Medicare] and are not allowable costs." 42 C.F.R. § 405.420(g). The Provider Reimbursement Review Board agreed with the findings of the fiscal intermediary that the cost of providing free care to indigents was a "charity allowance," and Congress never intended to allow participating hospitals to "charge back" this "obligated charity cost" to the Medicare program.

During the same 1977 fiscal year, St. James Hospital decided to furnish bedside telephones to all hospital patients, including Medicare recipients. In their annual report to the fiscal intermediary and in order to comply with the Secretary's regulations St. James entered the cost of this "personal comfort item" on worksheet A-8 of the 1977 Medicare Costs Report. The effect of this worksheet (A-8) entry acted as a "self-disallowance" of the overall patient telephone costs ($17,000) and thus the question of the telephone costs was not presented to the fiscal intermediary for review. St. James, at a later date, reconsidered this telephone cost reporting technique of "self-disallowance" and raised the issue and sought reimbursement for the cost of telephone service for the first time on its appeal to the Provider Reimbursement Review Board (PR Review Board). The PR Review Board consolidated St. James Hospital's appeal with that of a number of Florida hospitals on the issues of the telephone costs reimbursement and the disallowance of the percentage of free indigent care allocated by the hospitals to Medicare.

After a hearing on St. James' claim for patient telephone costs, the Board held that:

> "this Board does not have the authority to rule on coverage issues and is locked into the Regulation that states that the patient telephone is a luxury item.
>
> The Board finds that the controlling Regulations and Program Policy require the exclusion from allow-

able costs of all costs associated with telephone services and other personal comfort items which are used for the convenience of patients."

When the Board's decision on both questions became final, St. James filed suit in the Northern District of Illinois pursuant to 42 U.S.C. § 1395oo(f) asking for review of the decision of the Provider Reimbursement Review Board, and the parties filed cross motions for summary judgment.

In granting the plaintiff St. James Hospital's motion for summary judgment, Judge Leighton reasoned that the fiscal intermediary and the Board erred as a matter of law when they classified the rendering of a percentage of free medical services pursuant to the Hill-Burton obligation as "charity." The court reasoned that because St. James was obligated under its Hill-Burton grant agreement to provide a percentage of free care to indigents, the free care St. James provided indigents should not be considered as "charity." Moreover, the court further stated that the rendering of free services was "no different than costs which the hospital could have been required to pay as interest on the grants it received under the Hill-Burton Act." The court ruled that the Hill-Burton obligation of providing free care was not "charity" and that the Secretary's refusal to set aside the fiscal intermediary's disallowance was tantamount to "an abuse of discretion and not in accordance with law."

As to the issue of Medicare's reimbursement of patient telephone costs, the court found the Provider Reimbursement Review Board's decision that they were without jurisdiction to rule on the claim resulted in a "hypertechnical construction of the statute and regulations." The court ruled that the Provider Reimbursement Review Board had jurisdiction to review St. James' self-disallowance because the Board's jurisdiction may be invoked by a provider if the provider is dissatisfied with the amount of total program reimbursement and the amount in controversy exceeds $10,000, regardless of whether the fiscal intermediary was pre-

sented with the question of the reimbursement of the telephone costs.

Turning to the merits of St. James' claim for reimbursement of the expenses it incurred in furnishing bedside telephones to Medicare patients, the court noted that the telephones were used by both hospital personnel and patients alike. The district court found persuasive the expert medical testimony and clinical studies supporting the theory that bedside telephones had therapeutic value. While noting that the Secretary has broad discretion in adopting regulations governing payment to Medicare providers, the district court went on to find that the Medicare section disallowing reimbursement for "personal comfort items" was not intended to exclude the payment for patient telephones *per se*. Rather, the court reasoned that it was Congress' intent to exclude such items from coverage if they were required only for the convenience of a patient and had no meaningful relationship to the medical treatment of an illness or an injury or the functioning of a malformed body member. It was the court's decision that a bedside telephone had therapeutic value and was essential to the delivery of health care and therefore the Secretary of Health and Human Services abused his discretion in refusing to reimburse hospitals for the costs incurred in supplying Medicare patients with bedside telephones. The Secretary has appealed from the decision of the district court.

ISSUES PRESENTED

Issue 1: Is the cost of providing a percentage of free care to indigent persons pursuant to a hospital's obligation under the Hill-Burton Act reimbursable under Medicare as a reasonable cost of providing medical services?

Issue 2: Did the district court err in ruling that patient bedside telephones are not "personal comfort items" within the meaning of the Medicare Act?

1. *Hill-Burton Costs*[7]

Subchapter XVIII of the Social Security Act, entitled Health Insurance for Aged and Disabled, authorizes the payment of "reasonable costs" to qualified hospitals that provide medical services to Medicare beneficiaries and directs and empowers the Secretary of Health and Human Services to draft regulations to define and interpret what constitutes "reasonable costs" within the parameters of the Social Security Act. 42 U.S.C. § 1395x(v). On August 17, 1982, Congress passed section 106 of the Tax Equity & Fiscal Responsibility Act of 1982, and the bill became effective September 3, 1982. Section 106 provides:

> "(a) Section 1861(v)(1) of the Social Security Act [42 U.S.C. § 1395x(v)(1)] is amended by adding at the end the following new subparagraph:
>
> > '(M) Such regulations shall provide that costs respecting care provided by a provider of services, pursuant to an assurance under Title VI or XVI of the Public Health Service Act that the provider will make available a reasonable volume of services to persons unable to pay therefore, shall not be allowable as reasonable costs.'
>
> (b) The amendment made by subsection (a) shall be effective with respect to any costs incurred under Title XVIII of the Social Security Act, except that it shall not apply to costs which have been allowed prior to the date of the enactment of this Act pursuant to the final court order affirmed by a United States Court of Appeals."

Accompanying this provision the Congress included the following statements of congressional intent:

> *"House Committee Provision*
>
> The House Committee Provision requires the Secretary to provide, by regulation, that the costs in-

[7] For a discussion of the Hill-Burton Act, *see* note 4, *infra*.

curred by a hospital or skilled nursing facility in complying with its free care obligation under the Hill-Burton Act would not be considered reasonable costs for purposes of Medicare reimbursement. The provision is effective for costs incurred on or after date of enactment.

Conference Agreement

The Conference Agreement includes the House Committee Provision. *The provision is intended to clarify that Hill-Burton free care costs have never been, and are not, allowable for Medicare reimbursement purposes.* The provision, therefore, applies to all such costs that have been, or will be incurred except those recognized by the final judgment of a U.S. Court of Appeals entered into prior to enactment."

H. R. Rep. No. 97-160, 97th Cong., 2d Sess. at 431 (8/17/82) (emphasis supplied).

From the inception of the Medicare Program, the Secretary has adhered to the intent of Congress that Medicare was established exclusively to reimburse hospitals for the reasonable cost of providing medical treatment to those individuals who qualify as Medicare beneficiaries and not to reimburse hospitals for their charity obligations under the Hill-Burton Act. In response to the congressional mandate contained in section 106, the Secretary adopted regulations revising 42 C.F.R. § 405.420(b)(2), (g), "to state explicitly that uncompensated services furnished in fulfillment of a Hill-Burton free care obligation are considered charity allowances and as such cannot be considered allowable costs in computing Medicare reimbursement for providers." 47 Fed. Reg. No. 191 October 1, 1982 at 43657. In support of his regulation, the Secretary further noted:

"This rule is consistent with long standing Medicare policy in this area, and, as noted in the preceding section of this preamble, is explicitly required by Sections 1861(v)(1) of the Act (as amended by Sec-

tion 106 of Pub. L. 97-248). We believe this change will clarify our regulations and prevent further disputes with providers and others on this issue. . . .

Section 106 of Pub. L. 97-248 is effective with respect to all costs incurred under Medicare, both before and after enactment of the amendment, except those specific costs allowed under court order in the *Presbyterian Hospital decision. Consequently, this rule is applicable to all past disputes concerning Medicare disallowances of costs of free care furnished under a Hill-Burton obligation except those cost years specifically litigated in the Presbyterian Hospital* case, as well as future treatment of these costs. Any Hill-Burton costs paid by Medicare under the principle of the *Presbyterian* decision, but not specifically litigated therein, are impacted by this statutory amendment. These cost reports will be reopened and the Hill-Burton free care costs will be disallowed."

Id.

Saint Mary's and St. James' Hospitals challenge the congressional amendment and the subsequent regulations promulgated by the Secretary on the grounds that these governmental actions repudiate the hospitals' vested contractual rights to Medicare reimbursement for Hill-Burton indigent care costs and thus constitute a taking of property without just compensation in violation of the fifth amendment. Moreover, the hospitals assert that all patients should share proportionately in defraying the costs of providing the free care to indigents pursuant to the Hill-Burton Act because all patients benefit from the hospitals' use of Hill-Burton funds. Since the Secretary requires hospitals to accept Medicare patients if they previously received Hill-Burton funds and now refuses to reimburse those hospitals for the Medicare patients' share of the Hill-Burton charity care costs, the hospitals assert that they are being forced to operate at a loss when treating their Medicare patients. However, our review of the Medicare Act and the Hill-Burton Act reveals that these two Acts as established are two separate and distinct federal programs, each designed to accomplish a

distinctly different purpose. The Hill-Burton Act was designed to promote the construction and modernization of hospitals, and as a *quid pro quo* for the receipt of Hill-Burton funds, participating hospitals agreed to provide a percentage of charity care to local indigents. The Medicare Act, on the other hand, was adopted only to provide medical care for the disabled and the aged who qualify as Medicare beneficiaries. It was Congress' intent that these two programs remain separate and apart from each other and that hospitals should not be reimbursed by one program (Medicare) for the care they provide in fulfillment of the other, their Hill-Burton obligations. Thus, it is evident from the legislative history of the two Acts and the Secretary's long standing policy and from the language of the statutes that Congress never intended to allow the Medicare program to reimburse hospitals for a percentage of their annual Hill-Burton free care costs.

To date, two circuit courts of appeals have addressed the application of section 106 of the Tax Equity and Fiscal Responsibility Act of 1982. In *Harper-Grace Hospitals v. Schweiker*, No. 81-1305 (6th Cir. October 22, 1982), the Sixth Circuit applied section 106 and in doing so affirmed the decision of the district court that the costs of providing free care to indigents pursuant to the hospital's obligation as a recipient of Hill-Burton funds were not reimbursable costs under the Medicare Act. However, the court did not address the issue of the constitutionality of section 106, but rather relied upon the general rule that courts must apply the law that is in effect at the time the court renders its decision. *See Bradley v. Richmond School Board*, 416 U.S. 696, 711 (1974).

In a recent decision, the Eighth Circuit reversed the finding of the district court and held that the Secretary of the Department of Health and Human Services was correct when he relied on his regulation and denied the hospitals Medicare reimbursement for the costs the hospitals incurred in providing a percentage of free care to local indigents pursuant to the Hill-Burton contractual

agreement. *Metropolitan Medical Center v. Harris*, Nos. 81-2401, 82-1014 (8th Cir. Nov. 22, 1982). The court declined to rely on the retroactive application of section 106 of the Tax Equity and Fiscal Responsibility Act and instead rested its decision on the fact that the Hill-Burton Act and the Medicare Act embody separate and distinct federal programs and the legislative history of each revealed that Congress never intended to allow the use of Medicare funds to reimburse hospitals for the Medicare percentage of the free care rendered to indigents under the Hill-Burton Act. The court rejected the hospitals' claim that they had a right to Medicare reimbursement for the free care they provide to indigents as recipients of Hill-Burton construction aid because "[t]he text of the Act, its implementing regulations, its legislative history and the case law construing it all [demonstrate] that medicare reimbursement for free care costs is inconsistent with the Hill-Burton Act." *Metropolitan Medical Center*, Nos. 81-2401, 82-1014, slip op. at 12.

In another case, *Arlington Hospital v. Schweiker*, 547 F. Supp. 670 (D. Vir. 1982), the district court found section 106 constitutionally sound in the face of an attack based upon an uncompensated "taking" within the meaning of the fifth amendment. The court balanced the nature and the strength of the public interest served by section 106 against the nature of the hospital's asserted right to reimbursement and found that the "strength of the public interest involved, and the relative insubstantiality of the plaintiff's interest" required the court to uphold the constitutionality of section 106. *Id.* at 675. We agree with the overall reasoning of the Sixth and Eighth Circuit Courts and the specific reasoning in the *Arlington Hospital* case dealing with section 106, and in so ruling we hold that strong public policy outweighs the hospitals' insubstantial interest, and section 106 is clear in that it is nothing more than the reaffirmation of the longstanding policy that it was never the intent of Congress to allow Medicare payments to be used to reimburse hospitals for the percentage of free care they provide indigents in repayment of their obligations under the Hill-Burton Act.

To reach any other conclusion would put the government in the anomalous position of acting as a permanent life support system for health care facilities who provide services for the indigent without requiring that the hospitals fulfill the contractual obligations they incurred when accepting Hill-Burton funds. This type of financial reimbursement advocated by the hospitals is totally inconsistent with the principles of the Hill-Burton Act. We believe it is incumbent upon hospital executives to administer their respective hospitals in a fiscally responsible manner, contingent upon the reasonable cost of the services they provide within the limits of the Medicare guidelines. We refuse to permit hospitals to subvert federal aid programs through the use of other federal funds to subsidize the financial dilemma they themselves created.

It is well settled "that legislative acts adjusting the burdens and benefits of economic life come to the Court with a presumption of constitutionality and that the burden is on one complaining of a due process violation to establish that the legislature has acted in an arbitrary and irrational way." *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 15 (1976). In analyzing the constitutionality of retroactive legislation, case law suggests that courts undertake a balancing of three factors: (1) the nature of the asserted right that is altered by the legislation; (2) the nature and strength of the public interest served by the legislation; and (3) the extent to which the legislation impairs the asserted interest. *See Nachman Corp. v. Pension Benefit Guaranty Corp.*, 592 F.2d 947, 959-60 (7th Cir. 1979).

As to the first element, the hospitals' purported right to Medicare reimbursement for Hill-Burton uncompensated care costs was never expressly granted by either statute or regulation. Rather, this alleged right simply arises out of the hospitals' reading of the Medicare Act through rose colored glasses, a reading which is to the hospitals' pecuniary advantage, and the Fifth Circuit's interpretation of the Medicare Act and the Hill-Burton Act. *See Presbyterian Hospital of Dallas v. Harris*, 638 F.2d 1382

(5th Cir. 1981). However, neither the *Harris* decision nor the hospitals' reading of the Medicare Act rise to the level of establishing a "vested right" in hospitals to receive Medicare reimbursement for Hill-Burton uncompensated care costs, but merely represents a "hospital administrator's dream" and the wild expectation that hospitals should now receive even more government money for the services they have previously contractually agreed to provide to indigents in repayment of their Hill-Burton grants. There is not a scintilla of proof in this record that Congress ever intended the Medicare program to reimburse hospitals for the Medicare percentage of the cost of providing medical care pursuant to their Hill-Burton obligations.

The public interest to be served by section 106 is evident from our review of the legislative history of that section. Congress was acting to remedy what it perceived as a misinterpretation of the Medicare Act in recent litigation. There is clearly a strong public interest in the proper interpretation of congressional acts, and the adoption of section 106 by Congress was merely to clarify an already accepted fact that Medicare was never intended to provide hospitals with a second cash payment for the care they provide local indigents and is necessary to eliminate "windfalls from an unexpected judicial decision." C. Hochman, *The Supreme Court and Constitutionality of Retroactive Legislation*, 79 Harv. L. Rev. 692, 705 (1960). Furthermore, public policy supports the application of section 106 because to allow hospitals to use one federal program to fund their obligations under another in an attempt to "charge back" their excess costs to the government runs contrary to a reasonable reading of the two Acts. Therefore, we hold that section 106 is constitutional.

2. *Bedside Telephone*

Before reaching the merits of the district court's decision that patient bedside telephones are not "personal comfort items" within the meaning of the Medicare Act, we must first determine whether the district court had

jurisdiction to decide the question. 42 U.S.C. § 1395oo(g) states:

> "[t]he finding of a fiscal intermediary that no payment may be made under this subchapter for any expenses incurred for items or services furnished to an individual because such items or services are listed in section 1395y of this title shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f) of this section."

The Secretary contends that the courts do not have jurisdiction over the telephone cost reimbursement issue because the fiscal intermediary disallowed the cost of patient bedside telephones on the grounds they are "personal comfort items." Because the term "personal comfort item" is "listed in section 1395y," the Secretary asserts that section 1395oo(g) restricts the jurisdiction of the courts in the following language: "The finding of the fiscal intermediary . . . shall not be reviewed by the Board, or by any court . . . ." However, we do not agree with the Secretary's position that the telephone reimbursement cost issue cannot be reviewed by the courts. There is no definition or description of the term "personal comfort item" in the statute, and therefore, pursuant to his statutory duty and authority, the Secretary adopted regulations and interpreted the term "personal comfort item" to include personal telephones. Thus, we are faced only with a challenge to the Secretary's interpretation contained in his regulations of the term "personal comfort item." Contrary to the Secretary's position, section 1395oo(g) does not restrict this court's jurisdiction to review the Secretary's interpretation of what a personal comfort item consists of.

In a second challenge, the Secretary also contends that the Provider Reimbursement Review Board was without jurisdiction to act upon St. James Hospital's claim for reimbursement of the cost of bedside telephones because the hospital itself had "self-disallowed" the costs when they filed worksheet A-8 of their Medicare Costs Report. The Secretary takes the position that the relevant statutes require an initial presentation of the question of

the reimbursement of telephone costs to the fiscal intermediary before the hospital is entitled to a hearing by the Provider Reimbursement Review Board. 42 U.S.C. § 1395oo(d) provides that:

> "The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report *and to make any other revisions on matters covered by such cost report* (including revisions adverse to the provider of services) *even though such matters were not considered by the intermediary in making such final determination.*" (Emphasis supplied).

This section vests broad authority in the Provider Reimbursement Review Board to review the finding of the fiscal intermediary and make any adjustment to the cost reports the Board deems necessary. As the statute itself expressly states, the Board may consider any matter "even though such matters were not considered by the intermediary in making such final determination." 42 U.S.C. § 1395oo(d). Therefore, since the statute allows the Board to consider matters outside of the cost reports, we hold the Provider Reimbursement Review Board had the authority to consider whether the costs of providing Medicare patients with bedside telephones are reimbursable expenses under the Medicare Act.

Reaching the merits of the court's decision to overrule the Secretary and order reimbursement under the Medicare Act of the cost of providing Medicare patients with bedside telephones, we initially note that 42 U.S.C. § 1395hh grants the Secretary the broad discretionary power to "prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter." While Congress has mandated that no payment may be made for items "which constitute personal comfort items," 42 U.S.C. § 1395y(a)(6), Congress did not define the term "personal comfort item." Therefore, the Secretary of the Department of Health and Human Services, as the Administrator of the Medicare Program had the duty to draft and implement the following regulation defining the term "personal comfort item:"

"no payment may be made for any expenses incurred for the following items or services:

* * *

(j) Personal Comfort Items and Services (for example a television set, or telephone service, etc.);"

42 C.F.R. § 405.310.

It is the duty of the courts to interpret congressional acts, and though courts are not bound by interpretative regulations such as section 405.310, *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944), courts will defer to the agency's judgment unless it can be shown that the agency's determination was arbitrary and capricious or constituted an abuse of discretion. 5 U.S.C. § 706(2)(A). *See also Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402, 416 (1971). As recently stated by the Supreme Court, "there certainly is no reason to think judges or juries are better qualified than appropriate professionals in making such decisions. *See Parham v. J.R.*, 442 U.S. 584, 607, 99 S. Ct. 2493, 2506-2507, 61 L. Ed. 2d 101 (1979); *Bell v. Wolfish, supra*, 441 U.S. at 544, 99 S. Ct., at 1877 (Courts should not '"second-guess the expert Administrator on matters on which they are better informed."')." *Youngberg v. Romeo*, 102 S. Ct. 2452, 2462 (1982). The Secretary's regulation banning the reimbursement of the cost of a telephone used for a Medicare patient's personal comfort is clearly authorized by 42 U.S.C. § 1395y(a)(6). Since the Secretary has the broad authority to adopt regulations within the confines of the stated congressional intent, and because St. James has failed to show that the Secretary abused his discretion in determining that bedside telephones are personal comfort items, we hold that the cost of providing a Medicare patient with a bedside telephone is not a reimbursable cost under the Medicare program.

In sum, we defer to the professional expertise of the Secretary of the Department of Health and Human Services, and in doing so we uphold the Secretary's determination to exclude from Medicare reimbursement the

"average cost" of each telephone supplied to a Medicare beneficiary and we further hold that the Secretary's regulation which prohibits the reimbursement of hospitals for bedside telephones provided as personal comfort items to Medicare patients is valid and enforceable.

As pointed out earlier, we hold that section 106 of the Tax Equity and Fiscal Responsibility Act of 1982 which prohibits the reimbursement by Medicare of costs incurred by the provider hospitals in fulfillment of their obligation to provide a percentage of free care to indigents under the Hill-Burton Act is constitutional and thus, we affirm the decision of *Saint Mary of Nazareth Hospital v. Department of Health and Human Services*, and reverse *St. James Hospital v. Schweiker.*

A true Copy:

Teste:

Clerk of the United States Court of Appeals for the Seventh Circuit